Meeting Notes

1. Introductions by participants:
   - Ed Barthell, Chair
   - Sandy Bissen
   - Seth Foldy
   - Judy Fryback
   - Eric Heiligestein
   - Stacia Jankowski
   - Murray Katcher
   - Colette Lasack
   - Jeff Marcus
   - Dana Richardson
   - Denise Webb
   - Arthur Wendell
   - Fred Wesbrook
   - Susan Wood
   - Sandy Wright for Maureen Smith

2. Review of workgroup charter and timeline. The charter is attached. The expectation is that this group will make preliminary recommendations for consideration by the eHealth Board at the Board's next meeting on August 3, 2006. Following that meeting the group will continue working through November 2006 to drill down on the assignments in the charter and coordinate efforts with the other groups.

3. Briefing materials. Seth Foldy will develop resources for workgroup members in the form of Web links that will be available on the eHealth Board Web site (http://ehealthboard.dhfs.wisconsin.gov)

4. Discussion of methodology to establish highest priority patient care needs. Seth Foldy provided background on the approach taken in other states to rank possible solutions by both urgency and feasibility. Assumptions:

   - It is important to distinguish the different but related concepts of HIT (information technology built inside an enterprise) and HIE (exchange of interoperable information between organizations), understanding that the state roadmap must address both but will probably approach them differently in terms of financing and implementation strategies.

   - Both the Patient Care and Consumer Interests groups will make recommendations about which problems are most urgent to solve. Once both groups have identified the priority areas, the Information Exchange group will assess the feasibility of each. With this information, a matrix can be constructed to show the results. This is the approach used by Arizona for its roadmap and is a helpful way to approach a complex set of issues. (The Arizona report is published at http://www.azgita.gov/tech_news/2006/4_5_06.htm)

   Roadmap Prioritization based on both urgency and feasibility

	High Feasibility	Low Feasibility
High Urgency	Early (Years 1-2	Mid (Years 3-5)
Low Urgency	Mid (Years 3-5)	Late (Beyond 5)

5. Discussion of various solutions and the research needed to understand and rank them. Seth will provide a list of potential clinical care strategies to workgroup members for review and comment over the next week or so. The review is to see if the list is complete and the terms are understandable. This information will be used to develop a survey for the members and technical experts on the Patient Care Workgroup. Survey results will form the basis for discussion and prioritization at the next meeting of the group. Each person will be asked to rank the urgency of various options from a professional point of view and from a patient/caregiver point of view.

   Participants commented on key issues:

   • Fred Wesbrook noted that Marshfield has a well developed EHR system, with tablet computers in use at point of service, sophisticated diagnostic and electronic prescribing capabilities. They started on this in the early 1990s and found resistance to spending money and to moving to a standardized way of doing business. What finally made it meaningful to clinicians was having a basic set of information about the patient – diagnoses, medications, and progress reports. Based on this experience he believes the top priority is to provide this basic data set. He sees electronic prescribing as a very late development. From a patient point of view, his priorities are major diagnoses, medications and allergies.

   • Sandy Wright noted that the discussions in their research group have highlighted the need to have information that is easily accessed and easy to learn because physicians are working with so many different systems.

   • Dana Richardson made the distinction between information that is needed in the home area, the natural referral area between providers and what is needed statewide. Some data make sense to organize on a statewide basis – example is immunizations.

   • Colette Lasack – Their system is pretty far along with HIT – they cover three states and 19 counties – and she noted that it comes down to identifying the basic data set that is needed. She also noted the importance of aligning the state's work with national developments.

   • Murray Katcher concurred with the need for a basic data set and also noted the importance of thinking about quality of care and adherence to practice guidelines. For example both asthma and diabetes have significant morbidity, some mortality; there are good practice guidelines but they are not adopted uniformly. He also commented on the plans to do a survey of workgroup members and the drawback in having too narrow an audience. Results will reflect the bias of the group as opposed to being based on evidence. Medicine is trying to move from opinion-based practice to evidence-based practice and so too should the formulation of patient care strategies.

- Denise Webb noted support for the idea of a basic data set including the possibility of a smart card to store this information for patients.

- Judy Fryback commented on the needs of the DHFS, Disability Determination Bureau (DDB). DDB is one of the highest requestors of medical information – for purposes of determining eligibility for Social Security Disability and Medicaid benefits - and hopes to be able to do this more easily in the eHealth environment, reducing the administrative burden on the medical providers who supply the information and reducing overall costs.

- Sandy Bissen identified the cost savings that are possible by listing tests and services received, and medications dispensed and used, to reduce redundancy.

- Seth Foldy noted other potential benefits, such as reducing office staff, reducing billing lags, options for patients to see results without a provider as an intermediary.

- Ed Barthell noted the work going on nationally with the American Health Information Community, the advisory group to DHHS Secretary Mike Leavitt. They have four workgroups that are looking for early breakthroughs including establishing patient access to a personal health record, biosurveillance, increased use of electronic health records, and chronic care improvements.

- Arthur Wendell expressed his interest in a basic health record, including allergies, immunizations and a problem list, as well as significant interest in the quality and depth of the information for public health purposes.

- Jeff Marcus noted concern about how to correct information that is wrong in these records.

- Ed Barthell noted that we will never eliminate all errors and all risks and so will need policies and liability protection. There is a possible role for the state to provide some liability protection in this new environment.

- Fred Wesbrook noted that he is a great believer in patients having direct access to their records and a way to get incorrect information fixed.

- Ed Barthell noted that the model for eHealth Trust developed by Dr Yasnoff, who presented at the Digital Health Care Conference on May 4 in Madison, is based on a principle of personal responsibility of patients to manage their own health information.

- Dana Richardson noted that a master person index (MPI) is required to implement effective health information exchange.

- Ed Barthell indicated that the Information Exchange group will address options for how to do this including looking at how to leverage resources that already exist in the state as well as security architecture and what should occur regionally vs. statewide.

- Fred Wesbrook emphasized the role of this workgroup is to provide the vision– describing what this world should look like in five years. He noted that assuming there is some sort of data repository; this would be a good place to put practice guidelines such as Minnesota has done with national practice guidelines.

- Colette Lasack noted the importance of standardizing the way to provide insurance coverage information, either with this group or in one of the other groups, because of the significant administrative burden in the current system without any standardization.

- Ed Barthell suggested that once the workgroup has established its priorities for patient care solutions the focus should be to get two or three use cases written, perhaps by building on work that is being done in other regions or states.

6. Plans for stakeholder engagement. This same survey tool will be modified to use with the members of the other workgroups and with associations such as physician organizations. Workgroup members will help to identify the groups to contact.

7. Information on upcoming events:

   - First annual Nationwide Health Information Network Forum -sponsored by the Office of the National Coordinator in Bethesda MD June 28 – 29
   - Public Consensus meeting on statewide RHIO standards July 18 - 19 in Washington, D.C.
   - HIT Symposium, Cambridge MA July 17 -20

   Please let Susan Wood know about events coming up that offer resources to the eHealth work.

8. Meeting schedule and communication between meetings

   - Next two meetings are set for June 20 and July 18, both from 1- 4 PM in Madison. Meeting location and conference call information will be announced later.

Patient Care Information Support (Clinical Care) Charter

Responsibilities

Identify efficient, cost-effective and helpful ways for clinicians to share information that enables patients to get the right care in the right way at the right time.

Identify action strategies to achieve the goal of relevant and important electronic health information availability at the point of care for all providers and patients in Wisconsin within 5 years or as soon as practicable.

Design strategies to promote the adoption of electronic health records and decision support systems that are useful and used by clinical care providers as well as cost-effective for health care delivery systems.

Ensure that products and processes are responsive to consumer interests.

Assignment:

1) Define criteria (such as reach, feasibility and impact) to prioritize the key product types (such as Continuity of Care record or other abstract of medical history information, clinical care – public health business interoperability, e-Prescribe, use of statewide guidelines) and identify and prioritize the key product types to be implemented in the Action Plan.

2) Define use case examples (real-world examples) that are appropriate for the first key products.

3) Develop information on current use of electronic health records in Wisconsin.

4) Identify positive opportunities and barriers to wider adoption of electronic health information systems in all types of medical care settings. Recommend strategies to take advantage of opportunities and overcome barriers to foster statewide adoption.

5) Coordinate and give input to other workgroups.

6) Present findings, analysis, and recommendations to the Board at the August 3, 2006 meeting.